Providence
Medicare Advantage Plans

Information about Your Request to Access Your Protected Health Information (PHI)

What does my right to access my health information mean?

You or your personal representative have the right to inspect, review or get a copy of the information kept by Providence Medicare Advantage Plans in the designated record set (DRS) in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The designated record set is a group of records maintained and used by or for your plan, including certain records used to make decisions about you as a member. The DRS may include records pertaining to enrollment, claims, case management, medical management, or utilization management.

What do I need to understand to use this right?

- Your access to your records may have legal limits, such as in relation to health information not subject to the right to access information under HIPAA.
- You do not have a right to access PHI that is not part of the designated record set.
- You may not be entitled to receive all your PHI. For example, you will not receive information such as psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.
- Calls are recorded for quality and training purposes only. Providence Medicare Advantage Plans is not required to transcribe or produce a recorded call.
- Providence Medicare Advantage Plans will take reasonable efforts to produce the designated record set in the format you have requested. However, if Providence Medicare Advantage Plans cannot readily produce the records in the format requested, a mutually agreeable alternative will be established.
- ***This request is for access to your Providence Medicare Advantage Plans records. Should you require access to your medical/clinical/provider records, you will need to contact your provider's office and make a separate record request.***
- **Appeals and Grievances:** you may request a copy of the documentation collected/created by Providence Medicare Advantage Plans to respond to an appeal or grievance, at zero cost, by calling Customer Service at the toll-free number listed on your Providence Medicare Advantage Plans HealthCare ID card.
- If you are requesting the access for a minor, federal and state laws may prohibit Providence Medicare Advantage Plans from acting upon any request for information relating to sensitive services unless written authorization is received from the minor member.

How much will this cost me?

- Records provided at zero cost.

How will I know if my request is processed?

Providence Medicare Advantage Plans is committed to promptly responding to member requests. Providence Medicare Advantage Plans will adhere to the applicable federal and state laws which may require a more expedited response time. If for any reason we are unable to respond within the standard timeframe we will provide a written explanation for the delay. Please note that in certain situations your request may be denied. Should this occur, we will inform you in writing and let you know if and how you can appeal our decision.

Where do I send my request for access?

Please complete and sign the attached Member Request to Access Protected Health Information (PHI) Form and return it to Providence Medicare Advantage Plans at:

Mail:	Fax:	Deliver in Person:
Providence Medicare Advantage Plans Attn: Customer Service PO Box 5548 Portland Oregon 97228-5548	503-574-8608	Providence Medicare Advantage Plans 3601 SW Murray Boulevard Beaverton, Oregon, 97005 *Use main entrance on SW Murray Boulevard*

If you have any other questions or concerns, you may contact the Providence Medicare Advantage Plans Customer Service Team at 503-574-8000 or 1-800-603-2340.

If you are hearing impaired and use a Teletype (TTY) Device, please call our TTY line at 711. Customer Service assistance is available to answer questions, seven days a week, between 8 a.m. and 8 p.m. (Pacific Time).

Sincerely,

Providence Medicare Advantage Plans
Enclosure (form): Member Request to Access Protected Health Information (PHI)

Providence
Medicare Advantage Plans

Member Request to Access Protected Health Information (PHI)

Use this form to request a copy of your PHI in a Designated Record Set that Providence Medicare Advantage Plans or one of its Business Associates maintains. If you need assistance completing the form, please contact the Providence Medicare Advantage Plans Customer Service number listed on your member identification card. Please complete all the fields on this form.

PART A: MEMBER INFORMATION		
Member Last Name	**Member First Name**	**Middle Initial**
Member Date of Birth	**Member ID Number** ***(See your member ID card)***	**Group Number** ***(See your member ID card)***
Member Street Address	**City and State**	**ZIP Code**

PART B: DELIVERY OF THE REQUESTED INFORMATION

I request to review protected health information (PHI) about me in a designated record set held by Providence Medicare Advantage Plans. By checking the appropriate box below, I am indicating who should receive my information.

(select only one)

☐ Me at the address listed above

☐ Electronic or in-person pick-up, as indicated in Part C

☐ Send my PHI to the designated third party:

Name	Address	
City and State	Zip Code	Phone Number

PART C: FORMAT/MANNER OF THE REQUESTED INFORMATION

By checking the appropriate box below, I am indicating the format/manner I wish to receive/review my information. (Warning: Some level of risk may be associated with sending your PHI via unencrypted email or by mail, as your records could be accessed and read by an unauthorized third party.)

(select only one)

☐ Send paper copies of my records via US certified mail.

☐ Send electronic copy of my records via email. *Note: Information will be sent via secure (encrypted) email unless otherwise specified.*

Email address: _____ Initial if you wish email sent unencrypted: _____

☐ I want to pick up my records in person during regular business hours at the Providence Medicare Advantage Plans Beaverton office. I understand that I (or my personal representative) will be contacted to make arrangements.

☐ I want to view my records in person. I understand that I (or my personal representative) will be contacted to make arrangements.

PART D: DETAILS OF PHI REQUEST

I am requesting the protected health information (PHI) contained in the following records. (Please check the specific items you are requesting.)

☐ **Enrollment & Eligibility Information**

Date(s) of Enrollment: _____

Details of Request: _____

☐ **Claims Information, including Pharmacy (Summary of claims paid or denied)**
(This does not include information on claims received but not yet processed – if you would like the status of those claims you may call Customer Service at the toll-free number listed on your HealthCare ID card.)

Date(s) of Service: _____

Provider(s): _____

Details of Request: _____

☐ **Case or Medical or Utilization Management Information (Prior Authorization)**

Date(s) of Service: _____

Provider(s): _____

Details of Request: _____

☐ **Customer Service Inquiry (CSI)**

Date(s) of Service: _____

Details of Request: _____

☐ **Mental Health (Summary of claims paid or denied –** ***Note: If you check this box, please initial mental health below)***

Date(s) of Service: _____

Provider(s): _____

Details of Request: _____

I specifically authorize the release of the following sensitive information (if such are part of my record). I understand the following information will only be disclosed if I place my initials in the space next to the requested information. *I understand my alcohol/substance abuse records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations.

(Initial all that apply)

_____ **AIDS or HIV**	_____ **Maternity/Pregnancy (Reproductive Health)**
_____ ***Alcohol/Drug/Substance Abuse (Diagnosis, treatment, or referral information)**	_____ **Mental Health Data and Records**
_____ **Genetic Information (services or tests)**	_____ **Sexually transmitted illness/ disease (testing and treatment)**

☐ **Other Information**

Date(s) of Service: _____

Provider(s): _____

Details of Request: _____

PART E: MEMBER SIGNATURE AND DATE

_____ _____

Member Signature **Date**

- OR -

_____ _____

Member's Designated Legal Representative/Guardian Signature **Date**

Relationship to Member: ☐ **Parent** ☐ **Legal guardian*** ☐ **Holder of Power of Attorney***

***If this form is signed by someone other than the member or parent, please attach legal documentation if you are the Legal Guardian or Holder of Power of Attorney.**

Note to parents/legal guardians of minors: State laws may prohibit Providence Medicare Advantage Plans from acting on your request about Sensitive Information without written authorization from the minor member (both parent and minor must sign.)